Kansas Department on Aging

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURV	
,	5. GG.W.EG.WG.	152111111071110111102111	A. BUILDING: _	A. BUILDING:		.5
		N087067	B. WING		12/02/2	2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
AVITA SE	NIOR LIVING AT ROLLIN	G HILLS 629 SOUTI	H MAIZE COUF	RT		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d l	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
	resurvey with investig the above assisted liv 11/19/15, 11/23/15, 1 12/1/15, and 12/2/15.	s represent the findings of a lation of complaint #84254 of ring facility on 11/18/15, 1/24/15, 11/25/15, 11/30/15, Revised 2567 mailed to evision mailed 12/17/15.				
S3028 SS=E		f Treatment of Residents	S3028			
	exploitation shall be reported to the administration while the (C) Each alleged violation with reported to the administration of (B) Appropriate correctives notification of (B) Immediate measurement further potent exploitation while the (C) Each alleged violation with the (C) Each alleged violation in the alleged violation in (D) Appropriate corrective alleged violation in (E) The department in report shall be completed to the department with initial report. (F) A written record signature in the same and the same alleged violation in the department with initial report.	of an alleged violation. ures shall be taken to tial abuse, neglect, or investigation is in progress. ation shall be thoroughly e working days of the initial investigation shall be istrator or operator. ctive action shall be taken if s verified. s complaint investigation				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
	N087067	B. WING		12/02/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
AVITA SENIOR LIVING AT ROLLING	HILLS	TH MAIZE COUR KS 67209	T	
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIECT OF THE APPRO	D BE COMPLETE
to rule out abuse and /o Findings included: - Record review for res admission date of 11/4/ dementia with behavior and hypertension. The record contained fundated 10/4/13, 12/24/13 that indicated the reside short term memory, decrecall. The functional of 12/23/13, 9/14/14, and resident was at risk for The progress notes correntries when a staff me impaired resident on the documentation of what the floor: 8/25/14 resident found a.m. Unknown how residents.	census of 94 residents. residents. Based on view for 3 (#444, #777, s sampled, the eport to the department mediately initiate an aff member found a sident on the floor in order or neglect. sident #444 revealed an 12 and diagnoses of al disturbance, dysphagia, unctional capacity screens 3, 9/14/14, and 11/18/15 ent experienced impaired cision making and memory apacity screens dated 11/18/15 indicated the falls. stained the following mber found the cognitively e floor and entry lacked caused resident to be on on floor of room at 12:00 sident came to be on floor. skin tear to left cheek and	S3028		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
71127 2711	or contraction	IDENTIFICATION NO.	A. BUILDING: _		J J J J J J J J J J J J J J J J J J J	
		N087067	B. WING		12/0	2/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS 629 SOUTH WICHITA, P	I MAIZE COUF (S 67209	RT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S3028	Continued From page	e 2	S3028			
	8/30/14 at 9:48 p.m. r room with large skin t	resident found on floor in sear to right elbow, unable to ses, resident sent to the				
		at certified staff member or between bed and window.				
	9/27/14 at 4:20 p.m. at this resident on floor i	another resident reported in dining room.				
	1/9/15 at 8:36 p.m. St fall in room.	taff member heard resident				
	2/3/15 at 2:01 a.m. re outside of room.	esident sitting on floor				
	down by recliner in lo	resident found lying face unge area. Swelling to left area, 2 lacerations on lower ma inside lower lip.				
	•	0 0				
	3/20/15 at 4:01 p.m. f with bump to head.	ound on floor in dining room				
		resident found on floor in exit door. Resident unable Skin tear to left wrist.				
	inside room lying on a side and eyeglasses Resident had a large side of face and eye,	nurse found resident on floor abdomen with walker to left on right side on floor. bleeding hematoma to left sclera to left eye red and emergency room and found				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		N087067	B. WING		12	/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY, STA	TE, ZIP CODE		
AVITA SE	NIOR LIVING AT ROLLIN	G HII I S	SOUTH MAIZE COUR HITA, KS 67209	RT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S3028	Continued From page	3	S3028			
	to have concussion, f maxillary alveolar soc ecchymosis, and skin					
	4/23/15 at 4:15 p.m. r room.	esident on floor in dining				
	4/25/15 at 4:50 p.m. r room.	esident on floor in dining				
	5/18/15 at 2:15 p.m. F bathroom.	Resident found on floor in				
	6/14/15 at 9:56 p.m. 9:15 p.m. by certified	Resident found on floor at staff member.				
		certified staff member found or in front of medication cart.				
	7/10/15 at 1:41 p.m. s floor beside bed.	staff found resident sitting or	1			
	-	resident sitting on floor in nd door. Resident unable to				
	7/22/15 at 7:40 p.m. f with walker on top of	ound on floor in dining room resident.				
		resident found sitting on nt was last observed at sleep in bed.				
	nursing for facility inve	3/15, asked the director of estigation of times staff ent on floor and incidents tment.				
		3/15, director of nursing f-investigations for incidents				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		N087067	B. WING		12	/02/2015
	ROVIDER OR SUPPLIER	G HILLS 629 SOI	ADDRESS, CITY, STATE UTH MAIZE COURT A, KS 67209			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
\$3028	resulting a fractured of #444. At 4:30 p.m. on 11/23 stated he/she did not department all incider resident on floor. The administrator failed department within 24 initiate an investigation found cognitively important floor in order to rule of the compact of t	and 3/1/14 (witnessed fall elavicle) involving resident /15, director of nursing investigate or report to the nts of staff members finding ed to report to the hours and immediately n when a staff member aired resident #444 on the ut abuse and /or neglect. esident #777 revealed an 11/13 and diagnoses of etes mellitus, and ty screen dated 1/30/14 and d the resident was ng; required supervision y, transferring, and walking; with toileting; unable to of medications and lly continent of urine; short term memory, memory recall; experienced ed a walker or wheelchair for isk for falls.	S3028			
		Resident pointed to a picture				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		N087067	B. WING		12/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
AVITA SE	NIOR LIVING AT ROLLING	G HILLS	TH MAIZE COUP	रा	
(VA) ID	SHIMMADV ST	ATEMENT OF DEFICIENCIES	A, KS 67209	PROVIDER'S PLAN OF CORRECTION	IN (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
S3028	Continued From page	: 5	S3028		
	of a person and said thed.	they pulled him/her out of			
	lounge area. Large s	esident found on floor in kin tear found above left roximately 7 centimeters by			
	nursing for facility inve	3/15, asked the director of estigation of times staff ent on floor and incidents tment.			
	stated he/she did not	/15, director of nursing investigate or report to the nts of staff members finding			
	initiate an investigation found cognitively impa	ed to report to the hours and immediately in when a staff member aired resident #777 on the ut abuse and /or neglect.			
	admission date of 6/1	esident #555 revealed an 2/15 and diagnoses of etes, and hypertension.			
	indicated the resident eating; physical assis toileting, transferring, manage medications incontinent of urine; e term memory, decisio recall; impaired ability	cation; used a wheelchair			
	The progress notes co	ontained the following			

Kansas Department on Aging
STATEMENT OF DEFICIENCIES

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		N087067	B. WING		12/0	2/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS 629 SOUTH WICHITA, K	I MAIZE COUR (S 67209	RT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S3028	Continued From page	÷ 6	S3028			
	entries when a staff maintained resident on the	nember found the cognitively the floor:				
	bathroom floor. When	found resident sitting on n staff member asked ned, resident stated "I'm nat to do next."				
		resident on floor in front of hest position with chair front of chair.				
		resident on floor in front of guessed he/she slid off				
	11/2/15 at 11:15 a.m. resident on floor in front of lift chair. Lift chair in highest position and chair remote on floor.					
		3/15, director of nursing gate the times staff found				
	initiate an investigation found cognitively impa	ed to report to the hours and immediately on when a staff member aired resident #555 on the out abuse and /or neglect.				
S3081 SS=E	26-41-201 (c) Function Reassessment	onal Capacity Screen	S3081			
	requirements: (1) At least once ever	ne each resident ' s ecording to the following				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N087067	B. WING		12/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
AVITA SEI	NIOR LIVING AT ROLLING	G HILLS	ITH MAIZE COUF A, KS 67209	रा	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S3081	Continued From page	÷ 7	S3081		
	as defined in K.A.R. 2 (3) at least quarterly it assistance with eating assistant.	f the resident receives			
	This REQUIREMENT by: KAR 26-41-201(c)(1)(is not met as evidenced			
	The sample included record review and inte #777) of 6 residents s failed to ensure desig functional capacity so days and following an	a census of 94 residents. 6 residents. Based on erview for 3 (#111, 444, and eampled, the administrator nated staff conducted a reen at least once every 365 by significant change in e each resident's functional			
	Findings included:				
	admit date 3/15/13 wi heart failure, chronic o	esident #111 revealed an th diagnoses of congestive obstructive heart disease, a, cardiomyopathy and			
	(annual) recorded res with transfer, walking/ required supervision of required physical assi management of medion incontinence and exp				
	assist with bathing, dr	dminister medications, ressing, toileting that issist to get (resident) up			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
AVITA SE	NIOR LIVING AT ROLLING	G HILLS	TH MAIZE COUF , KS 67209	RT	
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S3081	and had to have assis Resident had a flare to became weak. Interview on 11/23/15 nurse/director of nurs resident had a change from hospital on 11/4/ significant change fun. The administrator faile staff conducted a funcresident #111 experie condition. Record review for readmission date of 11/dementia and dyspha. The record contained dated 9/14/14 and an capacity screen started. At 4:00 p.m. on 11/18 stated he/she had just capacity screen for the nursing provided a funcresident #444 dated 1. The administrator faile staff conducted a funcresident #444 at least - Record review for readmission date of 12/dementia, type II diab hypertension.	at 2:20 p.m. with licensed ing stated and confirmed in condition when returned its and did not complete a actional capacity screen. The did a significant change in conducted a significant change in conducted and diagnoses of gia. The director of nursing the conducted a functional capacity screen incomplete functional eresident. Director of inctional capacity screen for a capacity screen for a conducted a functional eresident. Director of inctional capacity screen for a capacity screen for a conducted a functional eresident. Director of inctional capacity screen for a conducted a functional eresident. Director of inctional capacity screen for a conducted a functional capacity screen for a conducted and diagnoses of esident #777 revealed an 11/13 and diagnoses of	S3081		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	= IED
		N087067	B. WING		12/0	2/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS 629 SOUTH	I MAIZE COUF (S 67209	RT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S3081	Continued From page	9	S3081			
	dated 7/24/14. The re	ecord lacked a subsequent reen within 365 days of the				
	At 4:15 p.m. on 11/23 confirmed the lack of capacity screen.	/15, the director of nursing an annual functional				
	staff conducted a fund	ed to ensure designated ctional capacity screen for tonce every 365 days.				
S3085 SS=E	26-41-202 (a) Negotia	ated Service Agreement	S3085			
	living facility or reside ensure the developme service agreement for the resident 's function service needs, and provide the resident or the representative, the cast to by the resident or the representative, the renegotiated service aground following information: (1) A description of the receive; (2) identification of the and (3) identification of each	nse manager, and, if agreed the resident 's legal sident 's family. The reement shall provide the				
	This REQUIREMENT by: KAR 26-41-202(a)(1)	is not met as evidenced				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 23 SOUTH MAZE COURT WICHITA, KS 2729 SUMMARY STATEMENT OF DEFICIENCIES PREFEX TAG SUMMARY STATEMENT OF DEFICIENCIES TAG CROSS REFERENCED TO THIS APPROPRIATE DEFICIENCY) S3085 Continued From page 10 The facility reported a census of 94 residents. The sample included 6 residents. Based on record review and interview for 3 (#444, #777, and #11) of for seidents sampled, the administrator failed to ensure the development of a written negotiated service agreement (NSA) for each resident, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident fault of the resident fault fault of the resident fault faul	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AVITA SENIOR LIVING AT ROLLING HILLS (XA) ID PREFIX TAG (XA) ID PREFIX TAG CONTINUED TO PROVIDERS PLAN OF CORRECTION (CA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG CONTINUED TO PREFIX TAG CONTINUED TO PREFIX TAG SOURCE TAG CONTINUED TO PREFIX TAG CROSS REFERENCES TO THE APPROPRIATE DATE DEFICIENCY SOURCE TAG CROSS REFERENCES TO THE APPROPRIATE DATE DEFICIENCY SOURCE TAG CROSS REFERENCES TO THE APPROPRIATE DATE CROSS REFERENCES TO THE APPROPRIATE CROSS						
AVITA SENIOR LIVING AT ROLLING HILLS (X4) ID PREFIX TAG (X5) CONTINUED FOR DEFICIENCY MUST BE PRECEDED BY FULL TAG (X64) ID PREFIX TAG (X64) ID PROVIDER TAG (X64) ID PREFIX TAG (X64) ID PROVIDED TAG (X64) ID PROVIDED TAG (X64) ID PR			N087067	B. WING		12/02/2015
CALLING AT ROLLING HILLS WICHITA, KS 67209	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
S3085 Continued From page 10 The facility reported a census of 94 residents. The sample included 6 residents. Based on record review and interview for 3 (#444, #777, and #111) of 6 residents sampled, the administrator failed to ensure the development of a written negotiated service agreement (NSA) for each resident; slegal representative that contained a description of services the resident would receive and the provider of each service. Findings included: - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia, dysphagia, and hypertension. At 4:05 p.m. on 11/18/15, the director of nursing provided a functional capacity screen started on 7/10/15 and finished on 11/18/15 that indicated the resident required physical assistance with bathing, dressing, tolleting, transferring, and mobility, was unable to perform management of medications and treatments; frequently incontinent of urine; experienced impaired short term memory, long term memory, decision making, and memory recall, was unable to understand communication or to communicate verbally; used a wheelchair for mobility; and was at risk for falls. The functional capacity screen documented the name of a hospice under the therapy/treatment section of the form.	AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS		₹Т	
The facility reported a census of 94 residents. The sample included 6 residents. Based on record review and interview for 3 (#444, #777, and #111) of 6 residents sampled, the administrator failed to ensure the development of a written negotiated service agreement (NSA) for each resident, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative that contained a description of services the resident would receive and the provider of each service. Findings included: - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia, dysphagia, and hypertension. At 4:05 p.m. on 11/18/15, the director of nursing provided a functional capacity screen started on 7/10/15 and finished on 11/18/15 that indicated the resident required physical assistance with bathing, dressing, tolleting, transferring, and mobility; was unable to perform management of medications and treatments; frequently incontinent of urine; experienced impaired short term memory, long term memory, decision making, and memory recall; was unable to understand communication or to communicate verbally; used a wheelchair for mobility; and was at risk for falls. The functional capacity screen documented the name of a hospice under the therapy/treatment section of the form.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
At 3:40 p.m. on 11/18/15, director of nursing provided an NSA for resident #444 dated 11/18/15. Director of nursing stated he/she just now completed the NSA. Review of the document revealed facility staff members	\$3085	The facility reported at The sample included record review and into and #111) of 6 reside administrator failed to a written negotiated seach resident, based capacity screening, spreferences, in collab the resident's legal readescription of service receive and the providereceive and the providereceive and the providereceive and the providereceive and the provided and functional 7/10/15 and finished the resident required bathing, dressing, toil mobility; was unable medications and treat incontinent of urine; eterm memory, long temaking, and memory understand communiverbally; used a wheeleat risk for falls. The fidocumented the name therapy/treatment second at 11/18/15. Director of now completed the N	esidents. Based on erview for 3 (#444, #777, ints sampled, the ensure the development of service agreement (NSA) for on the resident's functional ervice needs, and coration with the resident or expresentative that contained dees the resident would der of each service. esident #444 revealed an (#4/12 and diagnoses of and hypertension.) 8/15, the director of nursing capacity screen started on on 11/18/15 that indicated physical assistance with leting, transferring, and to perform management of timents; frequently experienced impaired short form memory, decision recall; was unable to cation or to communicate elchair for mobility; and was unctional capacity screen e of a hospice under the ction of the form. 8/15, director of nursing resident #444 dated nursing stated he/she just SA. Review of the	S3085		

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S3085	daily living, feeding as foods and honey-thick of medications and tre care. The NSA docur received services from provider. The NSA la services provided to the NSA lacked document the resident's family may representative in the case of the At 9:30 a.m. on 11/19 stated a hospice aide bathing 2 to 3 times at the hospice aide fed the During an interview at director of nursing statincontinence supplies assistance and feeding provided nursing assenursing confirmed the of services provided the nursing stated he/she resident's family mem the NSA. The administrator failed development of a writh based on the resident screening, service necollaboration with the legal representative the of services the reside provider of each service. Record review for resident services and feeding representative the fe	istance with all activities of sistance of ground texture kened liquids, management eatments, and incontinence mented the resident in an outside hospice cked a description of the resident by hospice. The tation of collaboration with member or legal development of the NSA. /15, certified staff member B assisted the resident with week and on those days the resident lunch. It 4:20 p.m. on 11/23/15, the sted hospice provided an aide provided bathing ag assistance, and a nurse tessments. Director of the NSA lacked a description by hospice. Director of a did not collaborate with the laber in the development of the NSA for resident #444, it's functional capacity eds, and preferences, in resident or the resident's nat contained a description in twould receive and the	S3085		
	dementia and type II	_			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS	ITH MAIZE COUI A, KS 67209	रा		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
S3085	Continued From page	e 12	S3085			
	indicated the resident eating; required supe dressing, transferring physical assistance was perform management treatments; was usual experienced impaired decision making, and for falls; experienced a walker or wheelcha. The record contained documented facility substitution assistance with activity management of medion and the NSA contained the provider as an outside. The NSA lacked a deprovided by hospice.	and walking; required with toileting; unable to to f medications and ally continent of urine; d short-term memory, I memory recall; was at risk impaired vision; and utilized air for mobility. If an NSA dated 5/29/15 that taff members provided ties of daily living and ications and treatments, the name of a hospice e agency providing services. Escription of services				
	director of nursing sta performed nursing as what the hospice aide Director of nursing co	sessments but did not know				
	based on the resident screening, service ne	tten NSA for resident #777, t's functional capacity eds, and preferences that on of services the resident				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N087067	B. WING		12/02/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE. ZIP CODE		
		629 SOI	JTH MAIZE COU	,		
AVITA SEI	NIOR LIVING AT ROLLING	G HILLS	A, KS 67209			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
S3085	Continued From page	e 13	S3085			
	admit date of 3/5/15 w congestive heart failur obstructive pulmonary sleep apnea, cardiom The functional capacit (annual) recorded res with transfer, walking/ required supervision was required physical assis management of medic incontinence and expert The Negotiated Service 6-1-15 recorded resid bathing, dressing, trantoxygen management,	y disease, hypertension, yopathy and Parkinson 's. ty screen dated 6/10/15 ident #111 was independent /mobility, eating, cognition, with bathing, toileting,				
	The record contained hospice care services	a written physician order for dated 11/10/15.				
	#111 stated, " Hospic him/her and the nurse	at 11:30 a.m. with resident the nurses/aides take care of the change dressing on left that arted a few weeks ago. "				
	nurses stated and cor	at 2:20 p.m. with director of offirmed the NSA lacked a provided by hospice.				
	based on the resident screening, service ne	ten NSA for resident #111,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDIEAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		OOWII E	LILD
		N087067	B. WING		12/0	2/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS 629 SOUTH WICHITA, K	MAIZE COUF S 67209	RT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S3085	Continued From page	e 14	S3085			
	would receive from ho	ospice.				
S3101 SS=E	26-41-202 (h) NSA Si	ignatures	S3101			
33 - E	the negotiated service agreement. The adm ensure that a copy of any subsequent revis	volved in the development of e agreement shall sign the inistrator or operator shall the initial agreement and ions are provided to the nt's legal representative.				
	This REQUIREMENT by: KAR 26-41-202(h)	is not met as evidenced				
	The sample included record review and into and #111) of 6 resider administrator failed to	ensure each individual opment of the negotiated				
	Findings included:					
	admission date of 12/ service agreement da	esident #777 revealed an (11/13. The negotiated ated 5/29/15 lacked the y representative, licensed nt's family member or				
	admission date of 6/1 service agreement da	ated 6/15/15 lacked the y representative, licensed				

		AND DUAN OF CORRECTION IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		N087067	B. WING		12/02/	2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS	'H MAIZE COUF KS 67209	₹Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S3101	Continued From page	e 15	S3101			
	representative.					
	admission date of 3/5 congestive heart failu Parkinson's disease, chronic obstructive punegotiated service aglacked the signature of	re, dementia, anemia,				
		ed to ensure each individual opment of the negotiated gned the agreement.				
S3155 SS=E	26-41-204 (a) Health	Care Services	S3155			
33-L	facility shall ensure the or coordinates the procare services that me resident and are in accordinate.	or residential health care nat a licensed nurse provides ovision of necessary health				
	This REQUIREMENT by: KAR 26-41-204(a)	is not met as evidenced				
	The sample included record review, interview (#333, #777, and #44	a census of 94 residents. 6 residents. Based on ew, and observation for 3 44) of 6 residents sampled, ed to ensure a licensed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		N087067	B. WING		12/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS	UTH MAIZE COUR A, KS 67209	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
S3155	Continued From page nurse provided and conecessary health care needs of each resider with the functional canegotiated service agreed in the functional canegotiated service agreed in the functional canegotiated service agreed in the functional capacitated and 9/14/14 recorded supervision with toilet walking/mobility, eating required physical assidressing, communicated unable to manage mecognition recorded differenced impaired vision, hearing, and efalls/unsteadiness. The negotiated service in the formula of the	e 16 coordinated the provision of e services that met the ent and were in accordance pacity screening and the reement. esident #333 revealed an with diagnoses of on, and anemia. ty screens dated 2/13/14 resident required ing, transfer, eg, bladder incontinence, istance with bathing, tion sometimes understood, edications/treatments, efficulty with decision making, decision making, impaired experienced	S3155		PRIATE DATE
	resident #333 require bathing, dressing, toil related to skilled reha	SP) dated 1/30/14 recorded d physical assistance with eting, nursing supervision b stay and fall with injury in dresident to speak slow			
	a four wheeled walke distances. Physical the (PT/OT) recommended wheelchair for most a continues to be impul making and choosing transfers. Staff to con	reech deficit. Resident uses and wheelchair for long herapy/Occupational therapy ed resident to use mbulation needs. Resident sive, with poor decision not to request help with hitinue to encourage and esident safety. Encourage to			

Kansas Department on Aging
STATEMENT OF DEFICIENCIES

	ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	` '	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
	N087067	B. WING		12/0	2/2015	
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE			
AVITA SENIOR LIVING AT ROLLING HILLS	S 629 SOUTH WICHITA, K	MAIZE COUR S 67209	रा			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST IN REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
lock wheelchair brakes when for assistance when things a Parkinson 's continues to w staff trying to keep room org to prevent falls and reaching. Additions to NSA/HCSP incl. 3/24/14 housekeeping to cle times a week due to clutter. on fall risk and how to prever 6/22/14 needs reminders are for assistance to allow staff to Resident fell in commons and walker and shuffled gait causto use wheelchair. 8/5/14 staff to assist with tying untied, encourage resident to back in chair as possible. Resident independently with to use wheelchair. 8/20/14 encourage to slow of stepping high. Resident not room. Staff still attempting to clutter, very difficult and residuse wheelchair. The progress notes recorded the following dates: 10/17/14 at 3:15 p.m. certification room. Resident was on the with dresser on top of him/heabove his/her head. Dresser resident who was lying flat of legs/arms to sides. Resident	are out of reach. Arorsen, family and ganized and picked up g to floor. Iluded: ean room at least 3 Resident educated ent. Ind encouraged to ask to pick up room. The after walking with used fall. Encourage Ing shoes when are to keep bottom as far Resident continued to the walker. Encourage Indown and think about the using walker in to keep room free of ident encouraged to Ind 11 falls between Ind additional falls on the ded staff called nurse the floor in bedroom ther and the TV just ther removed off on stomach, face, with	S3155				

NAME OF PROVIDER OR SUPPLIER AVITA SENIOR LIVING AT ROLLING HILLS STREET ADDRESS, CITY, STATE, ZIP CODE 629 SOUTH MAIZE COURT WICHITA, KS 67209 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AVITA SENIOR LIVING AT ROLLING HILLS 629 SOUTH MAIZE COURT WICHITA, KS 67209			N087067	B. WING		12/02/2015	
AVITA SENIOR LIVING AT ROLLING HILLS WICHITA, KS 67209	NAME OF P	PROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS DI AN OF CORRECTION OF	AVITA SE	NIOR LIVING AT ROLLING	G HILLS		KI		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPI	BE COMPLETE	
from couch to bed without walker, lost balance grabbing the dresser, then fell with everything landing on top of him/her. Resident complained of discomfort to head and lower back area where hit by drawers of the dresser. Redness to right backside and right back side of head. Abrasion on right lower back side measuring 5 centimeters (CM) by 2 CM. Just above is a red spot measuring 2 CM by 2 CM. Red area noted under right armpit. 11/1/14 at 2:41 p.m. notified that resident was on the floor in the bar. Resident got up by self. Resident pulled up pants leg and pointed to right knee. Resident pulled up pants leg and pointed to right knee. Resident able to move knee. Addition to NSA/HCSP 11/3/14 documented family continue to assist with keeping room clear and uncluttered. Family looking for services outside of the facility to come in two times weekly. Staff to assist resident with transfers in and out of chairs. Continue to encourage resident to keep room free of clutter and not to carry items while using walker. The progress notes recorded additional falls on the following dates: 11/11/14 at 4:45 p.m. Resident fell in front office and had gotten self-up. Steri-strips on hand and elbow. 11/13/14 at 3:20 p.m. notified that resident had fallen in the solarium area. Resident stated slid out of chair to floor. No injuries noted. 11/18/14 at 6:27 p.m. notified that resident fell in solarium. Resident stated slid off bench onto the floor. No injuries noted.	S3155	from couch to bed wit grabbing the dresser, landing on top of him/ of discomfort to head hit by drawers of the control backside and right backside and right backside and right lower backside and right backside and right lower backside and season in the bar. Resident pulled up pakene. Resident able to Addition to NSA/HCS family continue to assand uncluttered. Famoutside of the facility of Staff to assist resident chairs. Continue to eroom free of clutter arrusing walker. The progress notes rethe following dates: 11/11/14 at 4:45 p.m. and had gotten self-upelbow. 11/13/14 at 3:20 p.m. fallen in the solarium out of chair to floor. Note that the solarium is solarium. Resident wor a bench. Resident wor a self-upelbow.	thout walker, lost balance then fell with everything ther. Resident complained and lower back area where dresser. Redness to right ck side of head. Abrasion de measuring 5 centimeters above is a red spot CM. Red area noted under notified that resident was on desident got up by self. ants leg and pointed to right to move knee. P 11/3/14 documented dist with keeping room clear nily looking for services to come in two times weekly. It with transfers in and out of incourage resident to keep and not to carry items while ecorded additional falls on Resident fell in front office p. Steri-strips on hand and notified that resident had area. Resident stated slid No injuries noted. notified that resident fell in tras sitting on bottom in front a stated slid off bench onto	S3155			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
	N087067	B. WING		12/02/2015	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
AVITA SENIOR LIVING AT ROLLI	NG HILLS	TH MAIZE COURT ., KS 67209	•		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
resident was on the toward 1300 hall. Rewheelchair. Reside pick up newspaper a floor. Resident land 12/3/14 at 3:39 p.m. resident 's room du floor in front of room not using walker or was trying to practic balance and slid balanding on bottom. upper side from rub 12/10/14 at 12:43 a services clinic readi Report was being gipick up napkin off flowheelchair landing oback. Assisted residock brake while not in wheelchair. 12/17/14 at 5:00 p.m. the floor resting on estated heard knocki Opened door and the knocked resident do using walker. Obset blade and to both knocked resident fell out of opick up glasses . 12/23/14 at 1:28 p.m. Resident was seen.	kitchen staff stated that floor crawling in hallway desident got self-up and into ant stated was bending over to ads and dropped the paper on led on hands and knees. Inurse notified to go to be to fall. Resident was on an in hallway. Resident was wheelchair. Resident stated be walking in the hallway, lost ck against wall in the hallway. Dark pink mark to back right bing on the wall. Im. resident sitting in healthing a book at the table. In the hallway or and slid off edge of the or right buttock/hip then to dent up and encourage to moving and to sit way back on resident could be seen on the entrance to room. Resident not many and to resident not right shoulder.	S3155			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		N087067	B. WING		12/	02/2015
	ROVIDER OR SUPPLIER NIOR LIVING AT ROLLIN	G HILLS 629 SOL	ADDRESS, CITY, STATE JTH MAIZE COURT A, KS 67209			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3155	and fell to floor on both 1/7/15 at 10:54 a.m. rpm. last night and did area on left side of he cleansed and left ope 1/8/15 at 11:55 a.m. Fon 1300 hallway. Reswall. Resident stated sit on seated walker a against wall. Rednes 1/28/15 at 11:30 a.m. self-back into the whowas walking and just right shoulder along vnoted abrasion 7 CM side 11 CM long by .5 1/29/15 at 10:40 a.m. by the pool tables. Rand into wheelchair. wheelchair to floor. 2/6/15 at 10:42 a.m., wheelchair to floor who stated resident for expectation of the control	esident stated fell at 9:00 n't call anyone. Scraped ad 2 CM by 2 CM. Area n to air. Resident was found on floor sident was sitting against the was trying to turn around to and fell. Stated hit back s noted to mid back area. Resident fell and got selchair. Resident stated fell. Some redness noted to with right hip/leg. Left side long by 3 CM wide. Right of CM wide. notified resident on the floor resident was getting self-up Resident stated slid out of nile visiting with receptionist. notified resident had fall in itnessed by other residents sell to knees and got back up. call incident. Resident slid out of then got back up in chair. Resident found to have cut Resident stated rolled out of the floor this morning. Cut	S3155			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
		N087067	B. WING		12/02/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLING	G HILLS 629 SOU	TH MAIZE COUR	रा		
AVIIA OLI	NOR EIVING AT ROLLING	WICHITA	, KS 67209	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
S3155	Continued From page	21	S3155			
	resident that resident(lost balance and fell c	Nurse notified by another (#333) fell outside. Resident on the concrete. Resident ground and was sitting on es.				
	floor by the waterfall. leaning on the large b waterfall in lobby area words he/she said. N	resident reported on the Resident stated was brick island planter in front of a. Unable to understand loted 3 CM by 1 CM skin by. Steri strips applied and				
	floor in restroom. Res	notified that resident was on sident stated was standing lost balance in the process				
	3/26/15 at 7:42 p.m. F Resident situated bac	Resident fell in theater room. k in wheelchair.				
	Resident way lying or wheelchair facing him unable to give descrip Level of consciousnes responding to verbal s	n/her at feet. Resident of what happened. ss lethargic when stimuli. Speech rambling. with two staff. Hospice				
	ongoing risk of falls un down on floor when a provide dry surface for exiting the shower. R wheelchair brakes be continue to encourage of clutter. Hospice wi	ed revision to address the ntil 4/2/15: staff to lay towel ssisting with shower to or resident to step on when temind resident to lock fore standing. Staff to e resident to keep room free II provide additional service living and other hospice				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N087067	B. WING		12/02/2015	
NAME OF D	20) (IDED OD OUDDUED	OTDEET.	I DDDEGG OITY OTA	TE 710 000E	•	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	,		
AVITA SEI	NIOR LIVING AT ROLLING	G HILLS	JTH MAIZE COUR A, KS 67209	RT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
S3155	Continued From page	22	S3155			
	appropriate care.					
	nursing stated resider due to active hallucina disease getting worse to other residents in the go back in the kitcher. Interview on 11/19/15 nursing stated did not falls or any investigatistated resident was e in the wheelchair and resident had that man 4/1/15 and hospice in needed to move to an increased falls. For resident #333 whe falls in the 6 months puthe licensed nurse fail	at 3:25 p.m. with director of thave any means to track ions. The director of nurses incourage to sit back further stated did not realize in falls. Met with family on formed family resident #333 inother facility due to o experienced twenty-four preceding his/her discharge, led to provide and inhealth care services to				
		esident #777 revealed an 11/13 and diagnoses of etes mellitus, and				
	and 7/24/14 each indi independent with eati with bathing, dressing physical assistance w perform management treatments; was usua experienced impaired	lly continent of urine;				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED
N087067 B. WING	12/02/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 629 SOUTH MAIZE COURT WICHITA, KS 67209	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD FOR SH	OULD BE COMPLETE
S3155 Continued From page 23 impaired vision; utilized a walker or wheelchair for mobility; and was at risk for falls. The negotiated service agreement (NSA) /health care service plan (HCSP) dated 5/29/15 lacked interventions to address the resident's risk for falls. The progress notes recorded falls on the following dates: 1/24/15 at 5:52 a.m. resident slid off bed while attempting to take medications. 1/26/15 at 6:54 a.m. resident found on floor in bathroom doorway. Resident pointed to a picture of a person and said they pulled him/her out of bed. 1/27/15 at 9:56 p.m. resident found on floor in room between chair and wheelchair. Resident stated he/she was trying to transfer self from chair to wheelchair. 2/3/15 at 11:00 a.m. resident found on floor in dining room. Resident stated he/she slid out of wheelchair. 4/12/15 at 2:34 p.m. certified staff member found resident sitting on floor by bed. Resident stated he/she slid from bed. 4/12/15 at 6:00 p.m. Resident fell in dining room and received a 1 centimeter abrasion to right elbow. Resident stated was trying to walk to another table. 6/28/15 at 4:01 p.m. resident found on floor in lounge area. Large skin tear found above left	

MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 629 SOUTH MAZE COURT WICHTA, KS 67299 CAPITY CRAN DEPCISION Y MIST BE REFORMED BY PLUL REGULATORY OR LISE IDENTIFYING INFORMATION) PREFIX (EACH DEPCISION Y MIST BE REFORDED BY PLUL REGULATORY OR LISE IDENTIFYING INFORMATION) PREFIX (EACH DEPCISION Y MIST BE REFORDED BY PLUL REGULATORY OR LISE IDENTIFYING INFORMATION) PREFIX (EACH DEPCISION Y MIST BE REFORDED BY PLUL REGULATORY OR LISE IDENTIFYING INFORMATION) PREFIX (EACH DEPCISION Y MIST BE REFORDED BY PLUL REGULATORY OR LISE IDENTIFYING INFORMATION) PREFIX (EACH DEPCISION Y MIST BE REFORDED BY PLUL REGULATORY OR LISE IDENTIFYING INFORMATION) PREFIX (EACH DEPCISION Y MIST BE REFORDED BY PLUL REGULATORY OR LISE IDENTIFYING INFORMATION) PREFIX (EACH DEPCISION Y MIST BE ADDRESS REPREBUCED TO THE APPROPRIATE S3155 Continued From page 24 S3155 At 9:00 a.m. on 11/19/15, observed resident in bed in his/her room with wheelchair and walker beside bed. Resident awaske and oriented to self but not time or place. During an interview at 9:30 a.m. on 11/19/15, certified staff B stated resident 's in mode and the state of the state o	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
At 9:00 a.m. on 11/19/15, observed resident in bed in his/her room with wheelchair and walker beside bed. Resident was independent with ambulation. Certified staff B stated resident's is mood had improved receitly and had not fallen lately At 4:15 p.m. on 11/23/15, the director of nursing confirmed resident's nearest plan lacked interventions related to the resident's risk for falls. The administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services to address resident #777's risk for falls and unsteadiness. - Record review for resident #444 revealed an admission date of 111/4/12 and diagnoses of dementia with behavioral disturbance, dysphagia, and hypertension. The record contained a functional capacity screen			N087067	B. WING		12/02/2015
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) S3155 Continued From page 24 3.5 centimeters. At 9:00 a.m. on 11/19/15, observed resident in bed in his/her room with wheelchair and walker beside bed. Resident awake and oriented to self but not time or place. During an interview at 9:30 a.m. on 11/19/15, certified staff B stated resident with ambulation. Certified staff B stated resident's risk for falls. Certified staff b could not identify any interventions related to resident's risk for falls. The administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services to address resident #777's risk for falls and unsteadiness. - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia with behavioral disturbance, dysphagia, and hypertension. The record contained a functional capacity screen			G HILLS 629 SOL	ITH MAIZE COUR		
3.5 centimeters. At 9:00 a.m. on 11/19/15, observed resident in bed in his/her room with wheelchair and walker beside bed. Resident awake and oriented to self but not time or place. During an interview at 9:30 a.m. on 11/19/15, certified staff B stated resident was independent with ambulation. Certified staff B outled not identify any interventions related to resident's risk for falls. Certified staff B stated resident 's mood had improved recently and had not fallen lately At 4:15 p.m. on 11/23/15, the director of nursing confirmed resident's negotiated service agreement/health care service plan lacked interventions related to the resident's risk for falls. The administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services to address resident #777's risk for falls and unsteadiness. - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia with behavioral disturbance, dysphagia, and hypertension. The record contained a functional capacity screen	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETE
independent with transferring; required supervision with toileting, walking, and eating; physical assistance with bathing and dressing; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short term and long term memory, decision making, and memory recall; had difficulty communicating but could	S3155	3.5 centimeters. At 9:00 a.m. on 11/19 bed in his/her room we beside bed. Resident but not time or place. During an interview at certified staff B stated with ambulation. Certified staff B stated with ambulation. Certified staff B stated with ambulation of falls. Certified staff mood had improved relately At 4:15 p.m. on 11/23 confirmed resident's reagreement/health carrinterventions related to the administrator fails nurse provided and connecessary health carrinterventions related to the administrator fails nurse provided and connecessary health carrintervention with the administrator fails nurse provided and connecessary health carries ident #777's risk for admission date of 11/dementia with behavious and hypertension. The record contained dated 9/14/14 that inclindependent with transupervision with toilet physical assistance we unable to perform main and treatments; was a experienced impaired memory, decision maintenance.	/15, observed resident in ith wheelchair and walker to awake and oriented to self awake and oriented to self to 9:30 a.m. on 11/19/15, It resident was independent tified staff B could not ons related to resident's risk ff B stated resident 's eccently and had not fallen /15, the director of nursing negotiated service e service plan lacked to the resident's risk for falls. Led to ensure a licensed cordinated the provision of exervices to address or falls and unsteadiness. Lesident #444 revealed an 4/12 and diagnoses of oral disturbance, dysphagia, a functional capacity screen dicated the resident was sferring; required ing, walking, and eating; inth bathing and dressing; nagement of medications usually continent of urine; short term and long term king, and memory recall;	S3155		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		N087067	B. WING		12/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
		629 SOU	ITH MAIZE COUR	т	
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS	A, KS 67209		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE
S3155	Continued From page understand communicimpaired vision; used was at risk for falls. The record indicated capacity screen was a stated he/she had just capacity screen for the nursing provided a furesident #444 dated fresident #444 now rewith toileting, transfer was frequently inconticommunicate or under required a wheelchair to be at risk for falls. The health care services to Bathingadjust water directions to complete Dressing staff will segive resident having difficumedication and treatment in case of evacuation instruction and reassus Speech deficituse vipoint at to communicate on cassistance with mobil use of front-wheeled with provide mobility assist staff to observe resident resident construction and reassus staff to observe resident resid	cation; experienced a walker for mobility; and on 7/10/15 a functional started but not finished. 1/15, the director of nursing to conducted a functional eresident. Director of nctional capacity screen for 1/1/18/15 that indicated equired physical assistance ring, mobility, and eating; inent of urine; could not erstand communication; for mobility; and continued explain the communication; and give resident verbal explain the shower. Enture to the continued explain the continued ex	S3155		
	Mealsset up meal au History of fallsAssist	nd observe resident. I mobility with walker if			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
		N087067	B. WING		12/02/2015
	ROVIDER OR SUPPLIER	G HILLS 629 SOU	DDRESS, CITY, STATE TH MAIZE COURT , KS 67209		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S3155	assure room is free of place walker next to be resident to use if awal footwear; increase visiduring night time hour frequently; assist with around 9:00 p.m.; incresident in room; keep dining table when resident experienced with 11 falls in the pass. Progress notes docum 10/24/15 at 2:02 a.m. unable to bear any we for (resident)." Entry resident required physmeal and would not for self. During an interview at certified staff B stated assistance to total car living. Certified staff B history of falls but not had decreased. Certiinterventions to reduct was ambulatory staff or resident had walker a frequently but now ke area for staff member interview with certified #444 asleep in a recliif	the right or gait unsteady; if clutter or debris on floor; and at night to encourage kens; use appropriate sual checks of resident res; offer and assist toileting getting ready for bed rease visual checks when o walker placed close to ident in dining room. It is notes revealed the multiple falls since 12/24/13 at 6 months. Interest the last fall on and recorded "Resident is eight which has been normal 10/24/15 at 10:34 a.m. that sical assistance to eat a follow verbal cues to feed It 9:30 a.m. on 11/19/15, are sident required physical re with all activities of daily a confirmed resident had a longer able to walk so falls fied staff B stated risk for falls when resident members made sure and checked on resident pt resident in commons so to observe. During a staff B, observed resident mer in the commons area.	S3155		
	coordinated the provis	sion of necessary health			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			
		N087067	B. WING		12	2/02/2015
	ROVIDER OR SUPPLIER	G HILLS 629 SOL	ADDRESS, CITY, STATE JTH MAIZE COURT A, KS 67209	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S3155		ess resident #444's falls, and change in care needs.	\$3155			
\$3250 \$\$=F	living facility or reside ensure the maintenar resident in accordance professional standard (1) Designated staff's each discharged resident or older for at least fix of the resident. (2) Designated staff's each discharged resident resident reaches 18 years of age for at least resident reaches 18 years	or operator of each assisted intial health care facility shall ace of a record for each with accepted and practices. In a maintain the record of dent who is 18 years of age in years after the discharge whall maintain the record of dent who is less than 18	S3250			
	by: KAR 26-41-105(a) The facility identified at the sample included record review and interest all resident records, the ensure the maintenary accordance with access as evidenced by the conterventions changed.	a census of 94 residents. 6 residents. Based on erview with potential to affect the administrator failed to acce of a record in eptable standards of practice lates of health care plant to date of the last revision ion of resident discharge.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		N087067	B. WING		12/02/2015
	ROVIDER OR SUPPLIER	G HILLS 629 SOU	DDRESS, CITY, STAT TH MAIZE COUR , KS 67209		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
\$3250	showed dates of all hincidents and accident - Record review for readmission date of 11/4 dementia with behavior and hypertension. The record contained dated 9/14/14 that indindependent with transupervision with toilet physical assistance wound to perform mand treatments; was overeighted impaired memory, decision mand difficulty communicated vision; used was at risk for falls. The record indicated capacity screen was seat the last of	ealth care service plan ealth care services following ats with the same date. esident #444 revealed an 4/12 and diagnoses of oral disturbance, dysphagia, a functional capacity screen dicated the resident was sferring; required ing, walking, and eating; with bathing and dressing; nagement of medications usually continent of urine; short term and long term king, and memory recall; dication; experienced a walker for mobility; and on 7/10/15 a functional started but not finished. /15, the director of nursing t conducted a functional e resident. Director of anctional capacity screen for 11/18/15 that indicated equired physical assistance ring, mobility, and eating; inent of urine; could not erstand communication; for mobility; and continued ce plan dated 4/22/15 dent had an unwitnessed fall	S3250		
	and listed the followin	g interventions to be			

Kansas Department on Aging

Nalisas L	repartment on Aging					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		N087067	B. WING		12/0	2/2015
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DDRESS, CITY, STA	ATE ZIP CODE		
NAME OF T	TOVIDER OR 301 1 EIER		TH MAIZE COUF			
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS	, KS 67209	XI		
	OLUMBA DV OT		·	DD0//DDD0 D/ AV 05 00DD507/0		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
S3250	Continued From page	29	S3250			
	implemented by staff	members related to				
	resident's risk for falls					
		alker if resident is leaning to				
	the right or gait unste	<u> </u>				
		of clutter or debris on floor.				
	resident to use if awa	ped at night to encourage				
	Resident to use appropriate footwear. Increase visual checks of resident during night time hours. Offer and assist toileting frequently.					
	Assist with getting rea	ady for bed around 9:00 p.m.				
		s when resident in room.				
		lose to dining table when				
	resident in dining room					
	Each intervention cor 4/22/15."	ntained "Date initiated:				
	4/22/15.					
	Review of the resider	nt's previous negotiated				
		ealth care service plans				
	revealed the following					
	Offer and assist with	toileting frequently initiated				
	on 2/4/14					
	•	alker if resident is leaning to				
	•	ady initiated on 3/4/14.				
	Assure room is tree of initiated on 5/20/14.	f clutter or debris on floor				
		s when resident in room				
	initiated on 6/16/14.	Wilch resident in room				
		ped at night to encourage				
		kens initiated on 9/24/14.				
	Increase visual check	s of resident during night				
	time hours initiated or					
	Assist with getting real initiated on 9/29/14.	ady for bed around 9:00 p.m.				
	• •	lose to dining table when				
	resident in dining room	m initiated on 9/29/14.				
	The current negotiate	d service agreement/health				

care service plan dated 4/22/15 lacked

			SURVEY PLETED			
		N087067	B. WING		12	/02/2015
	ROVIDER OR SUPPLIER	G HILLS 629 SOL	ADDRESS, CITY, STATE JTH MAIZE COURT A, KS 67209			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
\$3250	are revised to the date. For resident #444 and all residents, the adm the maintenance of a acceptable standards. Review of records for identified a lack of doresident moved, who medications sent with transferred to and phytransfer/discharge. Interview on 11/19/15 nursing stated resident plus facility stated the document any dischational capacity and 11/19/14/14 recorded supervision with toilet walking/mobility, eating required physical assidressing, communical unable to manage mecognition recorded differenced impaired vision, hearing, and efalls/unsteadiness. The negotiated services are reviewed to the date of the date o	original date each hanges are made to be dates of all information of the change. If with the potential to affect inistrator failed to ensure record in accordance with of practice. It with the potential to affect inistrator failed to ensure record in accordance with of practice. It will be a considered to the consumentation of of what time resident left with, resident, where resident visician order for If at 3:10 p.m. with director of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices. It will be a consumentation of the discharged to a home ere is nurses do not rege notices.	S3250			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		N087067	B. WING		12/02/2015	5
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
AVITA SE	NIOR LIVING AT ROLLIN	IG HILLS 629 SOUTH	H MAIZE COUF KS 67209	₹Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMF	(5) PLETE ATE
S3250	resident #333 require bathing, dressing, toil related to skilled reha last 3 months. Remir and loud related to sp a four wheeled walked distances. Physical the (PT/OT) recommended wheelchair for most a continues to be impul making and choosing transfers. Staff to coroffer assistance for relock wheelchair brake for assistance when the Parkinson's continues staff trying to keep roof to prevent falls and resident for the progress notes and this time. Right up to heal. Brown scab in the progress notes for electronic medication (EMAR) recorded, "If the progress notes is what time resident momedications sent with transferred to and phy transfer/discharge. Interview on 11/19/15 nursing stated resider plus facility and confired to skilled the standard confired to and phy transfer/discharge.	ed physical assistance with leting, nursing supervision ab stay and fall with injury in and resident to speak slow beech deficit. Resident uses ar and wheelchair for long therapy/Occupational therapy ed resident to use ambulation needs. Resident lisive, with poor decision on to request help with intinue to encourage and esident safety. Encourage to see when standing and to ask things are out of reach. The see to worsen, family and som organized and picked up eaching to floor. The ecorded the following: The ecorded the following	\$3250			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		N087067	B. WING	· · · · · · · · · · · · · · · · · · ·	12	2/02/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
AVITA SEN	NIOR LIVING AT ROLLIN	G HILLS	TH MAIZE COURT	•		
	CLIMMA DV CT		A, KS 67209	PROVIDER'S PLAN OF CO	DDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
S3250	G3250 Continued From page 32		S3250			
		ed to ensure the ord for discharged residents eceptable standards of				
S3280 SS=F	26-41-104 (d) Disaste Preparedness	er and Emergency	S3280			
	disaster and emerger ensuring the performa (1) Orientation of new employment to the far management plan; (2) education of admission to the facility procedures; (3) quarterly review or management plan with and (4) an emergency dril at least annually with	ance of the following: employees at the time of				
	This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3)					
	The sample included interview and record in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ED
		N087067	B. WING		12/02/	2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
AVITA SEI	NIOR LIVING AT ROLLIN	G HILLS 629 SOUT WICHITA,	H MAIZE COUF KS 67209	रा		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETE DATE
S3280	Continued From page 33		S3280			
S3290 SS=E	planning, evacuation employees. Maintena not aware of a quarte management plan with and confirmed a quare emergency managem. For all residents and administrator failed to of the emergency managem.	sor provided a disaster process in-service with ance supervisor stated was rly review of emergency the residents and employees terly review of the nent plan not conducted. employees, the pensure a quarterly review nagement plan.	S3290			
	facility or residential hensure the provision of services to residents resident 's negotiated administrator or operates establishes a contract provide or coordinate services to the reside operator shall ensure with these regulations (b) Staff. The superv dietetic services shall employee. (1) A dietetic service shall provide supervision in each faresidents. (2) If a resident 's ne includes the provision mechanically altered	ator of each assisted living health care facility shall or coordination of dietary as identified in each discribed service agreement. If the ator of the facility to the provision of dietary nts, the administrator or that entity 's compliance is isory responsibility for be assigned to one vices supervisor or licensed escheduled on-site acility with 11 or more				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		N087067	B. WING		12/02/2015
	ROVIDER OR SUPPLIER	G HILLS 629 SOUT	DRESS, CITY, STAT TH MAIZE COUR KS 67209		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S3290	record, and the diet o prepared according to care provider or licens	n the resident 's clinical r liquids, or both, shall be o instructions from a medical	S3290		
	by: KAR 26-41-206(b)(2)				
	The sample included record review and inte of 2 sampled resident and #803) of 4 non-samechanically altered liquids, the administramechanically altered of the sample of th	ator failed to ensure the diet and/or thickened liquids ding to instructions from a			
	admission date of 11/dementia and dyspha screen completed 11/required physical assi record contained a moorder dated 6/27/15 for	esident #444 revealed an 4/12 and diagnoses gia. The functional capacity 18/15 indicated the resident istance with eating. The edical care provider's diet or mechanical soft foods gravy and honey thick			
	admission date of 6/1 dementia and type II of capacity screen dated resident required supplementary	esident #555 revealed an 2/15 and diagnoses of diabetes. The functional I 5/22/15 indicated the ervision with eating. The edical care provider's order			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		N087067	B. WING		12	/02/2015
	ROVIDER OR SUPPLIER	G HILLS 629 SOL	ADDRESS, CITY, STA JTH MAIZE COUF A, KS 67209			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$3290	with ground texture for At 2:40 p.m. on 11/23 provided a list of reside memory care units the altered and/or thicken maintained in the "aid resident # 444 require honey thick liquids, resident #800 ground consistency fluids, resident #800 ground consistency fluids, resident #803 ground consistency fluids. At 2:55 p.m. on 11/23 confirmed the lack of care provider or licens mechanically altered for all residents who altered diet, the admin mechanically altered	arbohydrate controlled diet ods. /15, the activity director dents that lived in the at required mechanically red liquids. The list re notebook documented and ground texture foods and regular consistency fluids, texture foods and regular texture foods and regular sident #801 regular texture at liquids, resident #802 regular texture foods and regular resture foods and regular foods and regular foods and regular foods and regular resture foods and regular food	S3290			